



LOS ANGELES COUNTY COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES May 21, 2015

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Fariba Younai, DDS, <i>Co-Chair</i>	Grissel Granados, MSW, <i>Co-Chair</i>	Louis Guitron	Jane Nachazel
Raquel Cataldo	Kevin Donnelly	Lambert Talley	Doris Reed
Derek Dangerfield	Suzette Flynn		
Terry Goddard, MA	David Giugni		
Kimler Gutierrez	John Palomo		DHSP STAFF
Carlos Vega-Matos, MPA	Maria Roman		Wendy Garland, MPH
			Sonali Kulkarni,, MD, MPH
			Amy Wohl, MPH, PhD

CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Standards and Best Practices (SBP) Committee Agenda, 5/21/2015
- 2) **Minutes:** Standards and Best Practices (SBP) Committee Meeting Minutes, 3/19/2015
- 3) **Minutes:** Standards and Best Practices (SBP) Committee Meeting Minutes, 4/16/2015
- 4) **PowerPoint:** Key Implementation and Evaluation Findings from the Medical Care Coordination Program, 5/21/2015
- 5) **Format:** Population-Specific Guidelines: Instructions and Formatting, 3/18/2015
- 6) **Graphic:** HIV Service Access & Utilization Determinants Framework, 5/21/2015
- 7) **Graphic:** Los Angeles County Continuum of HIV Services (Revised), 5/21/2015

1. **CALL TO ORDER:** Dr. Younai called the meeting to order at 10:05 am.
2. **APPROVAL OF AGENDA:**
MOTION #1: Approve the Agenda Order, as presented or revised (***Passed by Consensus***).
3. **APPROVAL OF MEETING MINUTES:**
Motion 2: Approve the 3/19/2015 and 4/16/2015 Standards and Best Practices (SBP) Committee meeting minutes, as presented or revised (***Passed by Consensus***).
4. **PUBLIC COMMENT, (Non-Agendized or Follow-Up):** There were no comments.
5. **COMMITTEE COMMENT, (Non-Agendized or Follow-Up):** There were no comments.
6. **CO-CHAIRS' REPORT:** ➡ Advise Ms. Granados she will be needed for the 6/18/2015 meeting as Dr. Younai cannot attend.
7. **COMMITTEE CO-CHAIR OPEN NOMINATIONS:** ➡ Mr. Goddard and Dr. Younai were nominated. Elections will be held in June.
8. **MEDICAL CARE COORDINATION (MCC) UPDATE PRESENTATION:**
 - Mr. Vega-Matos said MCC was developed by the Commission because the Non-Medical and Medical Case Management system was ineffective. Data showed many clients were not in medical care and case managers were not ensuring care.

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- MCC draws on a chronic disease management model with interventions by a team including an RN, a master's level social worker and others to coordinate care within a clinic and across services to help streamline service delivery. It also helped prepare for a changing healthcare landscape in which creation of medical homes for PLWH would be critical.
- MCC Standards of Care were approved in 2007. A transition advisory group including DHSP then met several times to develop an approach for implementation of this major system change. The group reviewed evidence-based strategies and models that could be standardized while remaining flexible. Previously Case Management services varied by provider.
- DHSP rolled out MCC in 2012 along with a new RFP for Ambulatory Outpatient Medical (AOM) Fee-For-Service (FFS). That coincided with Medicaid Expansion via Healthy Way LA and transition to ACA. Introducing MCC had strong support, but Mr. Vega-Matos has found it to be a kind of Rorschach test with people incorporating their own visions into it. DHSP has had to navigate implementation of a very different system in a quickly changing and unstable health care landscape.
- Ms. Garland, Supervising Epidemiologist, Office of the Medical Director, DHSP, presented on MCC. She has been developing the protocol which includes how to use Casewatch to support program evaluation.
- MCC integrates medical and psychosocial services to increase access and engagement in HIV care, reduce HIV-related health disparities and improve health outcomes. DHSP funds 20 agencies for MCC at 35 Ryan White (RW) HIV medical homes. The number of teams per clinic varies with clinic size and acuity levels of a clinic's patient population.
- Mr. Vega-Matos noted DHSP was aware many of its patients would eventually migrate to Medicaid Expansion or Covered California for medical care. The Commission wanted to ensure MCC would still be able to support such patients. RW, as payer of last resort, cannot fund services funded by other systems so DHSP purposely constructed MCC to be distinct from other funder services. MCC services are designed to coordinate seamlessly with those of other funders.
- Patients should be screened every six months and identified for active MCC services as needed based on criteria or referral. Patients may opt out. Those who accept are assessed across 12 domains of medical and psychosocial factors. An integrated care plan with pertinent brief interventions is developed among the patient, RN and social worker. MCC teams monitor improvement and revise the plan, as needed, until the patient achieves self-managed acuity status.
- Assessment is programmed in Casewatch to calculate domain/overall acuity and guide plan development and interventions. Higher outcome impact domains are weighted more heavily: health status, housing, mental health, and drug/alcohol abuse.
- Service guidelines were updated the prior week to include feedback from providers and streamline background material more pertinent when the service was new. All materials are on the website including the assessment and interventions.
- Training was also being streamlined. DHSP is assisting at provider sites to address challenges and hosting stakeholder meetings with the Department of Health Services (DHS), Community-Based Organizations (CBOs) and HIV testing providers.
- Casewatch data is also used to monitor and evaluate the program. Data was available from December 2012 through February 2015. Slide 13 reflects a steady enrollment increase with variations per month based on complete data. A few agencies have input assessment, but not service, data. DHSP was working with the vendor to ensure the two were linked. Some providers have also experienced difficulties in accessing Casewatch due to County IT changes to tighten security.
- Surveillance and Casewatch data are matched to evaluate 12-month periods pre- and post-MCC enrollment. Outcome measures are: retention in care, two or more CD4, Viral Load (VL) or resistance tests at least 90 days apart in the 12-month period; viral suppression, most recent VL <200 copies/ml) in second half of pre- and post-MCC 12-month periods. Post-MCC retention in care rates increased from 52% to 84% and viral suppression rates increased from 30% to 60%.
- The viral suppression rate is 33% and 73% of MCC enrollees are receiving ART. Demographic characteristic include: 78% at/below the Federal Poverty Level (FPL), 90% uninsured, 38% ever incarcerated and 14% homeless in the past six months.
- MCC patients by acuity level and service hours are: low, 18.4%, 12.5 hours; moderate, 51.7%, 17.6 hours; high, 30.0%, 20.9 hours; severe, 0.4%, 36.3 hours. Mr. Vega-Matos noted the service hours component was significant. Previously, moderate acuity clients of Non-Medical Case Management often absorbed the bulk of hours to the detriment of higher acuity clients.
- Ms. Garland noted high/severe acuity levels vary by group within some demographic populations, e.g., transgender, 52.0%; homeless, 46%; previously incarcerated, 39.9%; and at/below FPL, 34.1%. The domains most likely to need MCC were health status, 69%, and ART adherence, 68%. Approximately 80% with identified need received interventions.
- DHSP will continue to analyze outcome data and collaborate with CEPAC for cost effectiveness analysis. Mr. Vega-Matos noted MCC is an expensive program at \$9 million so cost effectiveness was crucial. He added contract performance measures track actual linkages, not simply referrals, to substance abuse, mental health, housing and income services.
- DHSP designed MCC to ensure providers can see patients who receive their medical care outside the RW system. Many providers have multiple funding streams, however, so most patients appear to be receiving services at their medical home. Mr. Guitron added such patients at the Los Angeles LGBT Center just need to fill out an eligibility form. Most patients screened for MCC are self-managed. Mr. Vega-Matos noted most RW medical care patients are also self-managed.

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- DHSP can access surveillance data for all PLWH, but not service data from non-RW medical homes unless patients sign a release. Another option would allow non-RW medical homes to apply for MCC, e.g., for a clinic that mainly serves a general safety net population. Free-standing MCC has also been suggested, but coordinating medical care would be very difficult.
 - Dr. Younai suggested a diagram delineating RW medical home MCC patients versus patients receiving medical services from other funders. Dr. Wohl replied the surveillance system only documents public, private or federal funding so the specific funder is only known for RW patients. The Medical Monitoring Project (MMP) includes a representative sample of PLWH in care in the County and includes some insurance data. Mr. Vega-Matos added providers previously submitted non-RW medical patient data since patients accessed other RW services, but initiation of AOM FFS reduced such data.
 - Dr. Wohl continued that one of the goals of the next Los Angeles Coordinated County HIV Needs Assessment was to identify barriers to care. Patients often, however, are not aware of who was funding their care.
 - Mr. Guitron said often patients identified as self-managed still need services. Ms. Garland replied MCC's goal is to retain PLWH in HIV medical care so the screening identifies retention barriers. Patients may have other issues, e.g., co-morbidities.
 - Mr. Vega-Matos said DHSP polled providers on how they defined "brief interventions." Common replies included help with bus passes and forms which are not interventions. Others wanted RNs to serve in the clinic instead of in case management.
 - Mr. Guitron remained concerned, e.g., one patient identified as self-managed was schizophrenic. Ms. Garland noted the provider can also refer a patient for MCC. Mr. Vega-Matos said initially some providers unsuccessfully attempted to enter service data prior to screening and assessment data. The system requires the screening and assessment data first.
 - Ms. Garland noted questions were raised at another meeting on how the MCC team might intervene with a light touch to defuse an issue for a self-managed MCC patient before it escalates. She will be reviewing data to assess such situations.
 - Mr. Vega-Matos added DHSP continues to discuss the meaning of "self-managed." All MCC patients should be able to access some services but, in practice, interventions outside a treatment plan start to look like the prior Non-Medical Case Management. DHSP continues working with providers to address challenges. One key challenge is that RNs and social workers are unused to collaborating. DHSP knows they do not always do so as assessments, treatment plans and progress notes for the same patient sometimes read as though they were for two different people. Training continues.
 - Mr. Gutierrez asked about Asian/Pacific Islander acuity levels. Ms. Garland replied there were only 38 A/PI individuals. That was insufficient for viable acuity data, but that will change over time as data accumulates.
- ➡ Additional questions on MCC can be emailed to DHSP.

9. POPULATION-SPECIFIC GUIDELINES:

- A. **Population-Specific Guidelines Format:** This item was postponed.

MOTION #3: Approve the Population-Specific Guidelines Format, as presented (**Postponed**).

- B. **Social Determinants Framework:** Dr. Younai noted SBP already accepted the Anderson model, as adapted, with areas most pertinent to the Commission highlighted in red. The revised Continuum graphic incorporates social determinants.

10. SERVICE CATEGORY DEFINITIONS:

MOTION #4: Approve the Service Category Clusters, as presented (**Postponed**).

11. NEXT STEPS:

- A. **Task/Assignment Recap:** There was no additional discussion.

B. **Agenda Development for Next Meeting(s):**

- ➡ DHSP will present on Linkage to Care in June and MMP in July.
- ➡ Schedule special meeting for 6/10/2014, 9:00 to 12:00 noon, to address the Population-Specific Guidelines Format, the Continuum of HIV Services (Revised) and Service Category Clusters as previously provided by Mr. Vega-Matos.

12. **ANNOUNCEMENTS:** There were no announcements.

13. **ADJOURNMENT:** The meeting adjourned at 12:05 pm.